AUTHORIZED MODIFIERS

Updated: 03/04/2014

A modifier provides the means for a provider to indicate that a service or procedure was altered by a specific circumstance but not changed in its definition or code. Pursuant to Administrative Rule of South Dakota (ARSD) §67:16:02:03.03, modifier codes must be included on a provider's claim for services if applicable. Reimbursement for services containing modifier codes is allowed according to ARSD §67:16:02:03.02. Modifiers not contained in this list may not be billed to the Department and may be cause for claim denial.

Modifiers used by the Division of Behavioral Health are designated *Division of Behavioral Health* in the following list.

South Dakota Medicaid claims are subject to a set of claims processing edits that are federally mandated. These edits, controlled by the Center for Medicare and Medicaid Services (CMS), are part of the National Correct Coding Initiative (NCCI). Modifiers relevant to the NCCI are designated *NCCI Associated* in the following list.

Code	Description	Payment Effect
22	**Increased Procedural Services** If the service provided is greater than that usually required for the listed procedure, it must be identified by adding modifier 22 to the procedure code. Documentation must support the substantial additional work. *Note: This modifier should not be used for E/M procedure codes.*	**125% Established Fee** **No Established Fee** 40% Usual and Customary Charge (UCC)
23	**Unusual Anesthesia** If a procedure which normally requires either no anesthesia or local anesthesia must be done under general anesthesia because of unusual circumstances, it must be identified by adding modifier 23 to the usual procedure code.	**100% Established Fee** **No Established Fee** 40% UCC
24	**Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period** Indicates than an E/M service was performed during the postoperative period for a reason unrelated to the original procedure. *Note: NCCI Associated*	None

Code	Description	Payment Effect
25	**Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Service** Indicates a significant, separately identifiable E/M service performed by the same provider on the same day as a procedure or other service. The significant, separately identifiable E/M service goes above and beyond the other service provided, or beyond the usual pre-operative and post-operative care associated with the primary procedure. *Note: NCCI Associated*	None
26	**Professional Component** Certain procedures are a combination of a physician component and a technical component. If the physician component is reported separately, the service must be identified by adding modifier 26 to the usual procedure code.	**30% Established Fee- Lab** **40% Established Fee- Non-Lab** **No Established Fee** 40% UCC
27	**Multiple Outpatient Hospital E/M Encounters on the Same Date** Utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient settings on the same date must be identified by adding modifier 27 to the usual procedure code. *Note: NCCI Associated*	None
47	**Anesthesia by Surgeon** Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. This does not include local anesthesia; local anesthesia is considered part of the basic procedure provided. *Note: Modifier 47 should not be used as a modifier for anesthesia procedures.*	**$16.00 for each unit**
50	**Bilateral Procedure** Unless otherwise identified in this listing, bilateral procedures requiring a separate incision that are performed at the same operative session must be identified by the applicable five-digit code describing the first procedure. The second procedure is identified by adding modifier 50 to the procedure code.	**150% Established Fee** **No Established Fee** 40% UCC

Code	Description	Payment Effect
51	**Multiple Procedures** If multiple procedures are performed on the same day or at the same session, the major procedure or service must be reported as listed. The secondary, additional, or lesser procedure or service must be identified by adding the modifier 51 to the secondary procedure or service code. This modifier must be used to report multiple medical procedures performed at the same session, as well as a combination of medical and surgical procedures or several surgical procedures performed at the same operative session. Bilateral procedures and surgical procedures which cannot stand alone but which are performed as a part of a primary surgical procedure are not considered multiple medical procedures and may not be reported with a 51 modifier.	**50% Established Fee** **No Established Fee** 30% UCC
52	**Reduced Services** Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided must be identified by its usual procedure code and the addition of the modifier 52 signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.	**75% Established Fee** **No Established Fee** 40% UCC
53	**Discontinued Procedure** If a procedure is started but discontinued because of extenuating circumstances or those that threaten the well-being of the patient, the service provided must be identified by its usual procedure code and the addition of the modifier 53.	**50% Established Fee** **No Established Fee** 40% UCC
54	**Surgical Care Only** If one physician performs a surgical procedure and one or more other physicians provide preoperative or postoperative management, surgical services must be identified by adding the modifier 54 to the usual procedure code.	**75% Established Fee** **No Established Fee** 40% UCC
55	**Postoperative Management Only** If one physician performs the postoperative management and another physician performs the surgical procedure, the postoperative component must be identified by adding the modifier 55 to the usual procedure code.	**25% Established Fee** **No Established Fee** 40% UCC

Code	Description	Payment Effect
56	**Preoperative Management Only** If one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component must be identified by adding the modifier 56 to the usual procedure code.	**25% Established Fee** **No Established Fee** 40% UCC
57	**Decision for Surgery** An E/M procedure that resulted in the initial decision to perform the surgery, identified by adding the modifier 57 to the appropriate E/M service. *Note: NCCI Associated*	None
58	**Staged or Related Procedure by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period** It may be necessary to indicate that a procedure during the postoperative period was (a) planned or staged; (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance must be documented by adding modifier 58 to the staged or related procedure. *Note: NCCI Associated*	None
59	**Distinct Procedural Service** Valid if attached to a procedure code that is distinct or independent from the other services performed on the same date of service. This includes a different session or encounter, different incision/excision, different organ, separate lesion. *Note: Modifier should not be used with an E/M service. NCCI Associated*	**100% Established Fee** **No Established Fee** 30% UCC
62	**Two Surgeons** If two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her operative work by adding modifier 62 to the procedure code.	**50% Established Fee for each surgeon**
73	**Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia** If a procedure is started but discontinued because of extenuating circumstances or those that threaten the well-being of the patient, the service provided must be identified by its usual procedure code and the addition of the modifier 73.	**50% Established Fee** **No Established Fee** 40% UCC

Code	Description	Payment Effect
74	**Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia** If a procedure is started but discontinued because of extenuating circumstances or those that threaten the well-being of the patient, the service provided must be identified by its usual procedure code and the addition of the modifier 74.	**50% Established Fee** **No Established Fee** 40% UCC
76	**Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional** If the physician repeats a procedure or service subsequent to the original procedure or service, the repeated procedure or service must be reported with its usual procedure code and the addition of a modifier 76.	**100% Established Fee** **No Established Fee** 40% UCC
77	**Repeat Procedure by Another Physician or Other Qualified Health Care Professional** If another physician repeats a procedure or service subsequent to the original procedure or service, the repeated procedure or service must be reported with its usual procedure code and the addition of a modifier 77.	**100% Established Fee** **No Established Fee** 40% UCC
78	**Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following the Initial Procedure for a Related Procedure During the Postoperative Period** If another procedure was performed during the postoperative period of the initial procedure and the subsequent procedure is related to the first and requires the use of the operating room, the procedure must be reported with its usual procedure code and the addition of a modifier 78. *Note: NCCI Associated*	**100% Established Fee** **No Established Fee** 40% UCC
79	**Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period** If another procedure or service is performed during the postoperative period and the subsequent procedure is unrelated to the original procedure, the procedure must be reported with its usual procedure code and the addition of modifier 79. *Note: NCCI Associated*	**100% Established Fee** **No Established Fee** 40% UCC

Code	Description	Payment Effect
80	**Assistant Surgeon** Surgical assistant services must be identified by adding modifier 80 to the usual procedure code.	**20% Established Fee** **No Established Fee** 40% UCC
81	**Minimum Assistant Surgeon** Minimum surgical assistant services must be identified by adding modifier 81 to the usual procedure code.	**20% Established Fee** **No Established Fee** 40% UCC
82	**Assistant Surgeon when qualified resident surgeon not available** The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code.	**20% Established Fee** **No Established Fee** 40% UCC
91	**Repeat Clinical Diagnostic Laboratory Test** If the same laboratory test is necessary on the same day to obtain multiple test results, the services must be identified by adding modifier 91 to the procedure code. *Note: NCCI Associated*	None
AA	**Anesthesia services performed personally by anesthesiologist**	**$16.00 per unit**
AD	**Medical supervision by a physician: more than four concurrent anesthesia procedures**	**$16.00 per unit**
AM	**Physician, team member service** Psychiatric Service *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
AS	**Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery**	**20% Established Fee** **No Established Fee** 40% UCC
BO	**Orally administered nutrition, not by feeding tube**	None
E1	**Upper left, eyelid** *Note: NCCI Associated*	None
E2	**Lower left, eyelid** *Note: NCCI Associated*	None
E3	**Upper right, eyelid** *Note: NCCI Associated*	None

Code	Description	Payment Effect
E4	**Lower right, eyelid** *Note: NCCI Associated*	None
EY	**No physician or other licensed health care provider order for this item or service** Social detox; City/County Meth Program Only *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
F1	**Left hand, second digit** *Note: NCCI Associated*	None
F2	**Left hand, third digit** *Note: NCCI Associated*	None
F3	**Left hand, fourth digit** *Note: NCCI Associated*	None
F4	**Left hand, fifth digit** *Note: NCCI Associated*	None
F5	**Right hand, thumb** *Note: NCCI Associated*	None
F6	**Right hand, second digit** *Note: NCCI Associated*	None
F7	**Right hand, third digit** *Note: NCCI Associated*	None
F8	**Right hand, fourth digit** *Note: NCCI Associated*	None
F9	**Right hand, fifth digit** *Note: NCCI Associated*	None
FA	**Left hand, thumb** *Note: NCCI Associated*	None
GT	**Via interactive audio and video telecommunication systems** Use this to indicate the service was provided via telehealth or telemedicine technology.	None

Code	Description	Payment Effect
HA	**Child/adolescent program** Substance Abuse Providers should use the HA modifier to indicate child or adolescent program. CMHCs should use the HA modifier to indicate Psych/CNP SED services. *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
HB	**Adult program, non-geriatric** CARE modifier for Psych/CNP services. *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
HD	**Pregnant/parenting women's program** *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
HE	**Mental health program** Substance Abuse Providers should use the HE modifier to indicate an individual service. CMHCs should use the HE modifier to indicate a Managed Care Exemption when providing a mental health service. *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
HF	**Substance abuse program** Slip/Slot *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
HG	**Opioid addiction treatment program** Intensive Meth Treatment Program; SD Women's Prison. *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
HH	**Integrated mental health/substance abuse program** Dual Diagnosis. *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
HK	**Specialized mental health programs for high-risk populations** IMPACT modifier for Psych/CNP services. *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
HQ	**Group setting** *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
HS	**Family/couple without client present** *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
HT	**Multi-disciplinary team** SEBH IMPACT. *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
HV	**Funded state addictions agency** Gambling Services *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules

Code	Description	Payment Effect
HW	**Funded by state mental health agency** CCS Impact, Transitional CARE. *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
LC	**Left circumflex coronary artery** *Note: NCCI Associated*	None
LD	**Left anterior descending coronary artery** *Note: NCCI Associated*	None
LL	**Lease/rental** Use the LL modifier when DME equipment rental is to applied against the purchase price.	None
LM	**Left main coronary artery** *Note: NCCI Associated*	None
LT	**Left side** Used to identify procedures performed on the left side of the body. *Note: NCCI Associated*	None
NU	**New equipment**	None
QK	**Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals**	**$16.00 per unit**
QM	**Ambulance service provided under arrangement by a provider of services**	See Transportation Services Fee Schedule
QX	**CRNA service: with medical direction by a physician**	**$16.00 per unit**
QY	**Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist**	**$16.00 per unit**
QZ	**CRNA service: without medical direction by a physician**	**$16.00 per unit**
RB	**Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair**	None
RC	**Right coronary artery** *Note: NCCI Associated*	None
RI	**Ramus intermedius coronary artery** *Note: NCCI Associated*	None
RR	**Rental** Use the RR modifier when DME is rented.	None

Code	Description	Payment Effect
RT	**Right side** Used to identify procedures performed on the right side of the body. *Note: NCCI Associated*	None
SA	**Nurse practitioner rendering service in collaboration with a physician** Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist. *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
SE	**State and/or federally-funded programs/services** LCBHS Impact. *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
SL	**State supplied vaccine**	**Payment limited to injection only**
SR	**SEBH IMPACT START PROGRAM** SEBH IMPACT START Program. *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
T1	**Left foot, second digit** *Note: NCCI Associated*	None
T2	**Left foot, third digit** *Note: NCCI Associated*	None
T3	**Left foot, fourth digit** *Note: NCCI Associated*	None
T4	**Left foot, fifth digit** *Note: NCCI Associated*	None
T5	**Right foot, great toe** *Note: NCCI Associated*	None
T6	**Right foot, second digit** *Note: NCCI Associated*	None
T7	**Right foot, third digit** *Note: NCCI Associated*	None
T8	**Right foot, fourth digit** *Note: NCCI Associated*	None
T9	**Right foot, fifth digit** *Note: NCCI Associated*	None
TA	**Left foot, great toe** *Note: NCCI Associated*	None

Code	Description	Payment Effect
TC	**Technical component** Under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number; technical component charges are institutional charges and not billed separately by physicians; however, portable x-ray suppliers only bill for technical component and should utilize modifier TC; the charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.	**70% Established Fee- Lab** **60% Established Fee- Non-Lab** **No Established Fee** 40% UCC
TK	**Extra patient or passenger, non-ambulance**	See Transportation Services Fee Schedule
TL	**Early intervention/individualized family service plan (IFSP)** Intensive Family Services. *Note: Division of Behavioral Health*	See Behavioral Health Fee Schedules
TN	**Rural/outside providers' customary service area** *Note: Division of Behavioral Health*	See Transportation Services Fee Schedule; See Behavioral Health Fee Schedules
UE	**Used Durable Medical Equipment**	